

MDR Tracking Number: M5-04-0457-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on October 14, 2003.

Requestor withdrew date of service 01-06-03 from their dispute on 03-24-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic procedures and application modalities were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 10-15-02 to 01-03-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 29<sup>th</sup> day of March 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division  
PR/pr

March 8, 2004

Rosalinda Lopez  
Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: MDR #: M5-04-0457-01  
IRO Certificate No.: IRO 5055

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or

other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Pain Management

## **REVIEWER'S REPORT**

### **Information Provided for Review:**

Correspondence  
H&P and office notes  
Physical Therapy notes

### **Clinical History:**

This claimant sustained a work-related injury on \_\_\_\_\_. He subsequently underwent lumbar surgery in September 1992, followed by lumbar fusion in August 2001. Additionally, the claimant had cervical spine surgery in November 1997.

On 09/04/02, the claimant was complaining of back and neck pain, with the neck pain radiating into the upper right arm. According to the initial physical therapy evaluation on 10/10/02, the claimant had increased pain complaints for the previous three months. Documentation reported that he had undergone prior surgery at C5-6. X-rays demonstrated disc narrowing at C4-5 and C5-6. The claimant was referred for surgical evaluation for further decompression and fusion surgery.

However, rather than see the physician, the claimant, apparently presented to the rehabilitation center on 10/10/02 for physical therapy. He received physical therapy consisting of hot packs, ultrasound, massage, and manual traction, as well as Williams' flexion exercises from 10/15/02 through 01/06/03. His initial pain level of 7-8/10 reduced to a level of 1-2/10 upon completion of seven weeks of physical therapy. On 12/09/02, approximately one month before the completion of physical therapy, the patient reported that much of his pain had decreased, although there was still residual discomfort in the right shoulder and weakness of the right arm. An additional four weeks of physical therapy was recommended.

### **Disputed Services:**

Therapeutic procedures and application modalities during the period of 10/15/02 through 01/03/03.

### **Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the procedures and treatments in dispute as stated above were not medically necessary in this case.

### **Rationale:**

This claimant underwent cervical spine surgery in November 1997. He had a flare-up of symptoms five years later and was referred for physical therapy. However, there was no attempt to treat the claimant with even an anti-inflammatory.

This would have been more appropriate than a physical therapy referral as the first and primary means of treatment for the pain flare-up.

Therefore, since the claimant did not have a more appropriate trial of medication management for his pain, especially given that the flare-up was some five years after cervical spine surgery in November 1997, there was no medical reason or necessity for the claimant to be referred for physical therapy as the first and only means of treatment for the pain flare-up.